ST. JOSEPH'S CARE GROUP
Sister Margaret Smith Centre

301 Lillie St. North
Thunder Bay, Ontario, P7C 0A6
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Referral Package
&
Program Information
Adult Intensive Residential Addiction Program

PG March/14

St. Joseph's Care Group Thunder Bay, Ontario

THUNDER BAY INTEGRATED ADDICTION SERVICES
CONSENT TO OBTAIN / RELEASE INFORMATION

The protection of your privacy and the delivery of high quality care is our priority. In order to best serve you, a group of service providers, all committed to the protection of your privacy, are working together to support your decisions regarding your care. With your permission, we will share information with each other and with other agencies to support you in developing a plan of care that is designed to support your choices and decisions.

The following agencies are part of a service system which is designed to support you in reaching your personal goals.

Thunder Bay Counselling Centre Addiction Services, Thunder Bay, ON	_____	Crossroads Centre Inc. Thunder Bay, ON	_____
St. Joseph's Care Group Addiction & Mental Health Services Thunder Bay, ON	_____	Children's Centre Thunder Bay New Experiences Program Thunder Bay, ON	_____
Alpha Court Community Mental Health Services Thunder Bay, ON	_____	Dilico Addiction Services Thunder Bay, ON	_____

If you are in agreement for the above named agencies and related programs to share assessment, treatment and case management information, please indicate your authorization by initialing beside each relevant agency.

In addition, there may be cause to share your personal health information with other care providers and agencies to support you in meeting your personal goals. If you are in agreement for the agencies listed below to obtain/release information with the authorized agencies in Thunder Bay Integrated Addiction Services please sign beside each agency indicating your authorization.

Consent to release/request information from the persons/agencies below:	Date	Signature
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

Having read and understood this form, I hereby authorize the identified agencies of Thunder Bay Integrated Addiction Services to Release/Request Information to/from each other and to/from the persons/agencies listed above. I also understand that I can withdraw my consent in writing at any time and that I can restrict the nature and type of information shared. This consent is considered valid for a period of six (6) months from the date of signature when it will be reviewed and renewed as required.

_____

Name (Please Print) D.O.B. (dd/mm/yr) Signature

_____ _____

Reviewed and Witnessed By Date

Substitute decision maker _____
(Please Print)

Signature:_____ Date:_____ Relationship:_____

SISTER MARGARET SMITH CENTRE
ADULT ADDICTION PROGRAMS
REFERRAL PROCESS FOR ADDICTION PROGRAMS

STEP 1: ASSESSMENT

The MOHLTC approved **Admission & Discharge Criteria & Assessment Tools** package should be completed for all referrals for substance abuse services. The ***Admission & Discharge Referral & Decision Tracking Summary*** must be forwarded, in addition to the BASIS-32 scoring sheets. We also require this SMSC Adult Addiction Program ***Referral Package*** be completed with the client. If you are unable to complete the assessment please contact Intake directly.

Referral of a Problem Gambling Client
For referral of any client with gambling issues to our addiction program, you must have the client fill out the SOPG, WHODAS 2.0 and the CATALYST PG data forms provided.

STEP 2: REFERRAL TO AN ADULT ADDICTION PROGRAM OPTION

The completed package is sent to **Intake for Adult Addictions** at the SMSC where it is reviewed based on the client admission criteria. Please include the completed Consent to Release Information form designating your agency so we can communicate information about the client as needed. Once the Intake team has reviewed all the documentation, they will contact the referent and the client to discuss potential start dates for their program option & any pre-admission requirements will be outlined in a letter- examples follow in Step 3 & 4.

STEP 3: ASSESS FOR WITHDRAWAL MANAGEMENT NEEDS

The expectation varies regarding the need for clients to be free from any alcohol or drug use (other than approved medications) depending on the program option they are requesting. If needed, clients may be referred to a withdrawal management program. Alternatives may be needed for the management of other withdrawal symptoms. These should be discussed with SMSC Intake.

STEP 4: ASSESS FOR STABILIZATION NEEDS

Some clients may require stabilization prior to participating in their choice of treatment option. Stabilization means readiness for the level of treatment and physically, mentally and emotionally stable. This can be done through community based services (case management, support group, medical or psychiatric services) and\or referral to a residential support program which offers stabilization services (ie Crossroads Centre). These should be arranged by the Case Manager in consultation with SMSC Intake.

STEP 5: ADMISSION TO THE TREATMENT OPTION

Once any pre-treatment requirements are met, the client will receive a letter which confirms their Admission date for their program choice, and includes an Information sheet outlining anything they may need to know about the program.

SISTER MARGARET SMITH CENTRE-
ADULT ADDICTION & PROBLEM GAMBLING PROGRAMS

INTENSIVE RESIDENTIAL TREATMENT
CLIENT ADMISSION CRITERIA

1. **MENTAL HEALTH-** The client must be capable of living in a group situation and participating in an intensive group treatment process. Anyone having attempted suicide within the last 30 days will not be accepted into the intensive residential program, as we are not a hospital, nor are we a Schedule 1 facility. Prescribed psychoactive medications for mental health conditions must have been reviewed by a psychiatrist or physician and pre-approved for treatment by Intake prior to admission.

2. **MEDICATION-** All medications, both prescribed and non-prescribed, must be reviewed and approved by Intake prior to admission. If the client arrives with any medications not previously approved, they will have to be reviewed by the Smith Centre's medical practitioner prior to taking the medication. In the case of life enhancing medications i.e. Dilantin, Nitroglycerin, the client must have medical clearance prior to admission.

   PLEASE NOTE: Benzodiazepines require written physician approval prior to the client being given an admission date. Due to Health & Safety concerns for both clients and staff, **Narcotic Drugs** (ie: oxycodone, morphine, codeine preparations) need to be reviewed by our medical consultants and a specialized plan developed for storage and delivery. (Categories as defined by the Office of Controlled Substances, Health Canada- see Appendix 1- Compendium of Pharmaceuticals & Specialties- 2010).

3. **METHADONE-** We accept clients on a Methadone program, **only** if they have been on the program for at least 2 months and on the same dosage for 2 weeks. They must have a clear screen (other than prescribed meds) for a week prior to admission. All methadone prescriptions must be transferred to a local pharmacy or clinic.

4. **PHYSICAL/COGNITIVE ISSUES-** Any physical health or cognitive impairments must be assessed for their interference with the client's ability to participate in the treatment program. Special dietary needs, limits to activity, memory, processing ability or other impairments may be able to be accommodated; however, the Smith Centre must be aware of them prior to admission.

5. **VIOLENCE-** Clients with current or previous charges or a history involving violence (physical or sexual) will be assessed for potential harm to staff and other clients, prior to acceptance of the referral. This is a co-ed facility with Men, Women and Youth Services treatment programs in the same building. We reserve the right to refuse admission to anyone, at any time, who could put the other clients and staff at risk.

6. **CONFIRMED TREATMENT DATE- Once we have all the information requested, a tentative Treatment date may be given in order to secure access to Pre-treatment services. The client must meet all the Pre-admission requirements listed for them to follow in order to receive a Confirmed Treatment date. A Treatment Date Confirmation form must be signed and returned to Intake. If these steps are not followed the client will likely lose their treatment date.**

ST. JOSEPH'S CARE GROUP
301 NORTH LILLIE ST.
THUNDER BAY, ONTARIO
P7C 0A6

SISTER MARGARET SMITH CENTRE
ADULT ADDICTION PROGRAMS
CLIENT ADMISSION PACKAGE

MEDITECH #: _____(SJCG)

CLIENT INFORMATION FORM	**REFERENT INFORMATION**
FIRST NAME: **MIDDLE NAME:** **LAST NAME:** **LAST NAME AT BIRTH:**	**DATE OF REFERRAL:** **REFERRING AGENCY:**
DOB:DD/MM/YEAR AGE: **GENDER: [ ] MALE [ ] FEMALE**	**NAME OF REFERENT:**
HEALTH CARD # : Province: **Status Number #:** **Ontario Works #:**	**AGENCY ADDRESS:**
STREET ADDRESS: **CITY: PROVINCE:** **POSTAL CODE:** **CONTACT BY MAIL: YES [ ] NO [ ]**	**POSTAL CODE:** **PHONE:** **FAX#:**
HOME PHONE # : **CALL ALLOWED:** YES [ ] NO [ ] **MESSAGE ALLOWED** YES [ ] NO [ ] **OTHER PHONE #:** **CALL ALLOWED:** YES [ ] NO [ ] **MESSAGE ALLOWED** YES [ ] NO [ ]	**CLIENT TYPE – PLEASE CIRCLE** 1. Client- Alcohol/Drug 2. Client- Alcohol/Drug/Gambling 3. Client- Gambling 4. Family member of Alcohol/Drug Client 5. Family member of Alcohol/Drug/Gambling Client 6. Other- Non-Addictions
CURRENT RESIDENCE (IF DIFFERENT FROM ADDRESS LISTED ABOVE) **PHONE #:**	**ETHNICITY- ETHNIC OR CULTURAL IDENTITY**: **PRIMARY-** **SECONDARY-** **STATUS #-**
EMERGENCY CONTACT: **RELATIONSHIP:** **PHONE #:**	**PREFERRED LANGUAGE:** **NEED FOR TRANSLATOR?**

SECTION 1- CATALYST ADMISSION INFORMATION

PLEASE CIRCLE THE NUMBER IN EACH SECTION THAT BEST FITS:

1. TREATMENT MANDATED\REQUIRED BY:

1. None
2. Choice between treatment or jail
3. Condition of probation/parole
4. Child Welfare Authority
5. Condition of employment
6. Condition of school
7. Condition of family
8. Other _____

6. INCOME SOURCE:

1. Disability insurance (WSIB)
2. Employment
3. Employment insurance
4. Family Support
5. None
6. ODSP
7. Ontario Works
8. Other Insurance
9. Retirement
10. Other _____

2. LEGAL STATUS:

1. No problem
2. Awaiting trial\sentencing
3. On probation- Start date: _____ (DD/MM/YEAR) End date:_____(DD/MM/YEAR)
4. On parole
5. Incarcerated
6. Other _____

3. RELATIONSHIP STATUS:

1. Married/partnered/common-law
2. Single (never married)
3. Widow or widower
4. Separated or divorced

7. PARENTING (CUSTOM FIELD):

1. Yes, with 1 or more child aged 0-6 years
2. Yes, with no children aged 0-6 years
3. Children in care of others
4. No children

4. EMPLOYMENT STATUS:

1. Employed full-time (includes self-employment)
2. Employed part-time
3. Unemployed (looking for work)
4. Student\ retraining
5. Disabled (not working)
6. Not in labour force
7. Retired

5. HIGHEST LEVEL OF EDUCATION:

1. No formal schooling
2. Some primary school
3. Primary school
4. Some high school
5. Completed high school
7. Some college
8. Completed college
9. Some university
9. University degree
10. How many years, in total, has the client spent studying in school, college or University?_____

SUBSTANCE USE & GAMBLING HISTORY

PRESENTING PROBLEM SUBSTANCES:

	SUBSTANCE USED	FREQUENCY IN LAST 30 DAYS- CIRCLE ONE	
MAJOR SUBSTANCE		1. Did not use 2. 1-3 times monthly 3. 1-2 times weekly	4. 3-6 times weekly 5. Daily 6. Binge
1ST OTHER SUBSTANCE		1. Did not use 2. 1-3 times monthly 3. 1-2 times weekly	4. 3-6 times weekly 5. Daily 6. Binge
2ND OTHER SUBSTANCE		1. Did not use 2. 1-3 times monthly 3. 1-2 times weekly	4. 3-6 times weekly 5. Daily 6. Binge

OTHER SUBSTANCES USED IN PAST 12 MONTHS: (Circle all that apply)

1. Alcohol
2. Amphetamines & other stimulants
3. Barbiturates
4. Benzodiazepines
5. Cannabis
6. Cocaine
7. Crack
8. Ecstasy
9. Glue & other inhalants
10. Hallucinogens
11. Heroin\ Opium
12. Methamphetamines (Crystal meth)
13. Other Psychoactive drugs
14. Over the counter codeine products
15. Prescription opioids
16. Steroids
17. Tobacco
18. Unknown
19. None

GAMBLING ACTIVITIES ENGAGED IN THE PAST 12 MONTHS:

1. Bingo - live/TV/radio
2. Slot machines
3. Gaming machines (other than slots)
4. Casino- Card/Table Games
5. Non-Casino Card/Table Games
6. Horse races-live/off-track
7. Sports betting (including Pro Line)
8. Lottery tickets
9. Instant win/scratch tickets (i.e. break open, pull tab, Nevada strips)
10. Internet Gambling
11. Gambling with Stocks/Options/Commodities/Real estate
12. Betting on games of skill i.e. pool, pitching pennies
13. Betting on the outcome of events
14. Other _____
15. None
16. Unknown

IS GAMBLING IDENTIFIED AS A PROBLEM? YES [ ] NO [ ]

HEALTH STATUS/PROBLEMS:

Visual impairment: **YES [ ] NO [ ]**
Hearing impairment: **YES [ ] NO [ ]**
Mobility/ physical impairment: **YES [ ] NO [ ]**

Pregnant: **YES [ ] NO [ ] POSSIBLE [ ]**

Non-medical intravenous drug use: **[ ] Never injected**
[ ] Injected prior to one year
[ ] Injected in last 12 months

Number of overnight hospitalizations in last 12 months for physical problems: _____

Reason for most recent hospitalization:_____

Diagnosed with a mental health problem by a mental health professional:

-within the past 12 months: **YES [ ] NO [ ]**

-within lifetime: **YES [ ] NO [ ]**

-most recent diagnosis:_____

Hospitalized for a mental health problem?

-within the past 12 months- **YES [ ] NO [ ]**

-within lifetime- **YES [ ] NO [ ]**

Received counselling/support/treatment for a mental health, emotional, behavioural or psychological problem from a community mental health program or professional?

-currently- **YES [ ] NO [ ]**

-within the past 12 months- **YES [ ] NO [ ]**

-within lifetime- **YES [ ] NO [ ]**

-name of current service provider: _____

-contact info for service provider: _____

Prescribed medication for a mental health problem:

-currently- **YES [ ] NO [ ]**

-within the past 12 months- **YES [ ] NO [ ]**

-within lifetime- **YES [ ] NO [ ]**

HEALTH CONDITIONS/PROBLEMS

Please check all that apply:

[ ] allergies
[ ] blood pressure problems
[ ] cancer
[ ] chronic pain
[ ] diabetes
[ ] Eating disorders (bulimia, anorexia, over eating)
[ ] HIV/AIDS
[ ] heart disease
[ ] Hepatitis A
[ ] Hepatitis B
[ ] Hepatitis C
[ ] history of head injuries
[ ] history of seizures/epilepsy
[ ] jaundice
[ ] kidney disease
[ ] lice/scabies
[ ] liver disease
[ ] menstrual/menopausal difficulties
[ ] respiratory
[ ] STD (syphilis, gonorrhea, chlamydia, herpes)
[ ] stomach/gastrointestinal problems
[ ] thyroid problems
[ ] tuberculosis

Provider of Primary Health care (doctor, nurse practitioner, health clinic): _____

Contact information for provider of health care: _____

PRESCRIBED DRUGS

Drugs currently prescribed:

On Methadone or opioid substitute: **YES [ ] NO [ ]** Prescriber:_____
Do you experience drowsiness, or fall asleep within 2 hours of taking your methadone dose? (Y/N)_____
If Yes, have you discussed this with your prescriber?_____

Prescribed Drug	Prescriber & Phone #	Prescription Details

NOTES ON HEALTH STATUS:

SECTION 2- ADDITIONAL INFORMATION- ALL REFERENTS COMPLETE:

REFERRAL INFORMATION:

1. What circumstances have made the client request treatment at this time & how did the client come to know about our services?

_____

_____

_____

2. Describe the nature of your involvement with the client.

_____

_____

_____

3. What supports are you providing or able to provide on a pretreatment basis?

_____

_____

_____

4. What supports does the client have access to in the community? What supports/services has the client accessed to date? (If the client has not accessed services please explain why)

_____

_____

_____

SYMPTOMS / TREATMENT HISTORY:

1. Please put an X by all **addiction related** symptoms the client has experienced:

[ ] feeling sluggish, without energy
[ ] headaches
[ ] rapid heart rate
[ ] passing out
[ ] flashbacks / tracers
[ ] seeing / hearing things not really there
[ ] poor concentration
[ ] chronic cough
[ ] disrupted sleep
[ ] nausea / vomiting
[ ] shakiness, unsteady hands
[ ] blackouts
[ ] sweating
[ ] poor memory
[ ] nose bleeds
[ ] Other (specify)_____

2. Attempting to quit or cut down can be difficult, has the client previously tried to quit or cut down on their

Substance use? No_____ Yes_____ How many times ?_____

Gambling? No_____ Yes_____ How many times ?_____

3. What were the circumstances that caused the client to make changes with his/her use during these times?

_____

_____

_____

4. What has been the longest period of maintained change?_____

5. What did the client find helpful during those periods?

_____

_____

_____

6. Where does the client place him/herself on the continuum of use? (Please determine for each substance used – whether they are "problematic" or not).

Drug # 1_____	Drug # 2_____	Drug # 3_____	Drug # 4_____
[ ] No Use	[ ] No Use	[ ] No Use	[ ] No Use
[ ] Social/recreational use	[ ] Social/recreational use	[ ] Social/recreational use	[ ] Social/recreational use
[ ] Habitual Use	[ ] Habitual Use	[ ] Habitual Use	[ ] Habitual Use
[ ] Problematic use	[ ] Problematic use	[ ] Problematic use	[ ] Problematic use
[ ] Abuse	[ ] Abuse	[ ] Abuse	[ ] Abuse
[ ] Dependence	[ ] Dependence	[ ] Dependence	[ ] Dependence

7. What is the client's current substance use goal?

[ ] quit all substance use/gambling
[ ] maintain abstinence
[ ] other_____
[ ] cut down on _____
[ ] make no changes

8. What is the client's current gambling goal?

[ ] quit all substance use/gambling
[ ] maintain abstinence
[ ] other_____
[ ] cut down on _____
[ ] make no changes

9. Previous addiction treatment: No previous treatment attempts- [ ]
Yes, **FILL IN TABLE BELOW**

PLACE	**WHEN**	**TYPE OF TREATMENT**	**COMPLETE?**

9. What did the client find most helpful about their past treatment experience(s)?

_____

_____

10. What did the client find most challenging about their past treatment experience(s)?

OTHER NOTES ON SYMPTOMS/TREATMENT HISTORY:

EMOTIONAL HEALTH:

PLEASE ANSWER YES OR NO AND PROVIDE INFORMATION ON HOW THE CLIENT HAS COPED AND WHAT SUPPORTS HAVE BEEN UTILIZED

CONCERN	EXPERIENCED IN LAST 90 DAYS (Y/N)	EXPERIENCED IN LIFETIME [YEAR OR AGE(S)]	RECEIVED TREATMENT (Y/N)	SUPPORTS/COPING SKILLS USED
Anxiety- tension, nervousness fears / phobias				
Depression- grief, losses, isolation				
Sexual abuse / sexual assault				
Abuse- physical, emotional, mental abuse				
Suicide- suicidal thinking, attempts, self-harm behaviour				
Cognitive- difficulty tracking , concentrating, focusing				
Anger- assaults, aggressive behaviour				
Other trauma (eg. deaths, losses, accidents, other events)				

NOTES ON EMOTIONAL HEALTH **(INCLUDING MENTAL HEALTH /DIAGNOSIS DETAILS)**

OTHER POTENTIALLY EXCESSIVE BEHAVIOURS:
PLEASE CHECK THE BOXES BELOW IF THEY ARE RELEVANT. PROVIDE DETAILS IN THE SPACE PROVIDED. *Ie. Amount of time spent doing this activity, negative life impact, causes financial strain, topic of arguments with loved ones).*

☐ **NONE**

	√	**DETAILS**
Shopping (excessive money spending)	☐	
Computer overuse	☐	
Internet overuse (surfing, chatting, blogging, social networking)	☐	
Video Gaming (computer or home systems, online)	☐	
Eating Disorder (starving on purpose, binging purging)	☐	
Sex (pornography, masturbating, sex, visiting sex trade workers, preoccupation with thoughts)	☐	
Other	☐	

LEISURE ACTIVITIES:

1. What type of activities does the client do for fun? (past and current)

FAMILY/SUPPORTS:

1. What community is the client originally from?_____

2. Childhood Experiences:

[ ] Substance abuse of mother/father
[ ] Witness to violence
[ ] Emotional, physical or sexual abuse
[ ] Inconsistent care provision
[ ] Death of a parent
[ ] Divorce/separation of parents
[ ] Foster Care (# of years_____)
[ ] Inconsistent care providers

3. How does the client describe the relationship with his/her family of origin?

4. Relationship Experiences:

[ ] Never been in a relationship
[ ] Affairs
[ ] Mental health issues of partner
[ ] Difficulties talking about feelings
[ ] Violence/abuse
[ ] Solid/supportive relationship

5. If the client is currently in a relationship, does the partner struggle with any addiction issues?

6. Does the client have any children? [ ] Yes [ ] No
If yes, who has custody of the children? What is the nature of the relationship with the children?

7. Is there any family history of mental health or addiction?

8. Do you have a secret life? [ ] Yes [ ] No

Comments:

NOTES ON FAMILY/SUPPORTS

ECONOMIC / EMPLOYMENT / EDUCATION:

1. Current or last occupation? _____

2. Does the client have EAP in the workplace? _____

3. If not working, what is the client's source of income? _____

4. If attending school, which program? _____

5. Does the client have a learning disability? YES [ ] NO [ ]
   If yes, what type:_____

   Were there any academic accommodations made in school? _____

How does the client best learn new information? (IE: verbally, observing, participating, hands-on, reading, etc.)

_____

NOTES ON EDUCATION / EMPLOYMENT-

LEGAL:

1. Any current charges? YES [ ] NO [ ]

2. If yes, what are they?_____

   When is the next court date?_____

3. If on probation or parole…

   What charges is the client on probation for? _____

   Probation or parole officer's name: _____

   Contact Information: _____

4. Past Offenses (check all that apply):

[ ] theft / possession of stolen property
[ ] drug charges
[ ] weapons offenses
[ ] robbery
[ ] arson
[ ] impaired driving
[ ] parole / probation violations
[ ] forgery
[ ] burglary, break & enter
[ ] assault
[ ] sexual assault / incest
[ ] willful damage / mischief
[ ] murder / manslaughter, criminal negligence causing death
[ ] other – (specify):_____

NOTES ON LEGAL-

GOALS FOR TREATMENT:

1. What are the client's goals for treatment?

2. What does the client see as important areas to explore in treatment in order to achieve those goals?

3. What group experiences has the client had to date? (What did they like/dislike?)

4. What is the client's availability for treatment?

5. What does the client see as the biggest barrier or potential barrier for attending a treatment program?

STRENGTHS AND RESOURCES:

1. What gives the client hope?

2. What does the client see as his/her personal strengths?

_____

_____

_____

_____

PRE-TREATMENT PLAN FOR CLIENT:

Pre-treatment service suggested to client	Yes \ No	Agency Suggested
Withdrawal management services (Detoxification)		
Stabilization prior to treatment- supportive housing, individual counselling, meetings.		
Medical Services- medication management, physical assessment, medical procedures.		
Psychiatric Services- psychological or psychiatric assessment, medication stabilization.		
Other (specify)_____		

SUMMARY NOTES

_____ _____

Signature of Client Date

_____ _____

Signature of Counsellor Date

ST. JOSEPH'S CARE GROUP

SOPG
Sister Margaret Smith Centre
Problem Gambling Services

Thinking about the last 12 months…

1. Have you bet more than you could really afford to lose?
   Never — Almost always
   Sometimes — Don't know
   Most of the time

2. Still thinking about the last 12 months, have you needed to gamble with larger amounts of money to get the same feeling of excitement?
   Never — Almost always
   Sometimes — Don't know
   Most of the time

3. When you gambled, did you go back another day to try to win back the money you lost?
   Never — Almost always
   Sometimes — Don't know
   Most of the time

4. Have you borrowed money or sold anything to get money to gamble?
   Never — Almost always
   Sometimes — Don't know
   Most of the time

5. Have you felt that you might have a problem with gambling?
   Never — Almost always
   Sometimes — Don't know
   Most of the time

6. Has gambling caused you any health problems, including stress or anxiety?
   Never — Almost always
   Sometimes — Don't know
   Most of the time

7. Have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?
   Never — Almost always
   Sometimes — Don't know
   Most of the time

8. Has gambling caused any financial problems for you or your household?
   Never — Almost always
   Sometimes — Don't know
   Most of the time

9. Have you felt guilty about the way you gamble or what happens when you gamble?
   Never Almost always
   Sometimes Don't know
   Most of the time

10. In the past 12 months, what was the largest amount of money you have gambled with (to the nearest dollar)?

11. Check which of the following people in your life has (or had) a gambling problem:

Father	grandparent	child(ren)
Mother	spouse/partner	another relative
Brother/sister	friend, or someone important in my life	

12. In the past 12 months, have you ever claimed to be winning money gambling but weren't really? In fact, you lost.
   Never
   Yes, less than half the time I lost
   Yes, most of the time

13. In the past 12 months, have you ever felt like you would like to stop gambling but didn't think you could?
   Yes No

14. In the past 12 months, have you neglected household or other responsibilities in order to gamble, or to get money to gamble?
   Yes No

15. In the past 12 months, have you ever hidden betting slips, lottery tickets, gambling money or other signs of betting or gambling from others?
   Yes No

16. In the past 12 months, have you ever argued with people you live with about how you handle money?
   Yes No

17. (If you answered "yes" to question #16) Have money arguments ever centered on your gambling?
   Yes No

18. (If you answered "yes to question #17) Have you had a secret life, regarding your money, because of your gambling?
   Yes No

19. In the past 12 months, have you ever borrowed from someone and not paid them back as a result of your gambling?
   Yes No

20. In the past 12 months have you ever lost time from work (or school) due to gambling?
   Yes No

21. Have you ever used gambling to:
    a) avoid conflict? Yes No
    b) change your mood? Yes No
    c) escape from "life"? Yes No

22. If you borrowed money to gamble or pay debts, in the past 12 months, who or where did you borrow from?
    a) from household money……. Yes No
    b) from spouse/partner……... Yes No
    c) from other relatives or in-laws……... Yes No
    d) from banks, loan companies, or credit unions…… Yes No
    e) from credit cards……..... Yes No
    f) from loan sharks…….. Yes No
    g) cashed in stocks, bonds, or other securities……. Yes No
    h) sold personal of family property…….…. Yes No
    i) borrowed on chequing account (passed bad cheques)…. Yes No
    j) you have (had) a line of credit with a bookie…….. Yes No
    k) you have (had) a credit line with a casino…….. Yes No

23. On a scale of 1-10 (1= no problem with gambling, 10 being a serious gambling problem), how do you rate the level of problems surrounding your gambling?

    I rate my gambling problem…_____/10_

24. How many years ago would you have rated yourself a 5 (5 being "moderate degree of problems" on the scale?)

PSGI Score:_____/27_____ (to be completed by SMSC clinican)

Comments:

Sister Margaret Smith Centre
CATALYST data form

Please complete the following questions:

1. Are you seeking help for:
   O Your own difficulties related to a family/significant others gambling **STOP HERE**
   O Your own gambling problem **PLEASE CONTINUE**
   O Both **PLEASE CONTINUE**

2. Looking back now, for how many years has your gambling affected your life in negative ways?
   _____ Years _____ Months

3. Please indicate how long it has been since you last gambled: Record the number of years, months, weeks or days.
   _____

4. Please indicate whether:
   O You came to this agency specifically for gambling treatment
   O Your gambling problem surfaced in the course of other treatment

5. (a) Please indicate how often you engaged in each of the following gambling activities in the past 12 months. Please check the most appropriate box.

Gambling Activities:	Did not gamble	Less than once a month	1-3 times monthly	1-2 times weekly	3-6 times weekly	Daily	Unknown
1. Played cards for money							
2. Played Mahjong for money							
3. Played “live” KENO for money							
4. Played roulette for money							
5. Bets on horses, dogs or other animals							
6. Bets on sports							
7. Bets on dice games							
8. Bought lottery tickets							
9. Bought scratch tickets							
10. Bought tear open tickets							
11. Played bingo for money							
12. Played the stock options and/or commodities market							
13. Played VLTs							
14. Played slots or other non- VLT machines							
15. Internet gambling							
16. Played pool, golf or some other game of skill for money							
17. Participated in Sports Pools							
18. Betting spontaneously on random events/informal bets							

19. Some other type of gambling							

5. (b) Please indicate the top three types of gambling problems, using the activity numbers in question 5(a).
   Major _____ 1st other _____ 2nd other _____

6. (a) Please indicate how often you gambled in each of the following locations in the last 12 months. Check the most appropriate box.

Locations:	Did not gamble	Less than once a month	1-3 times monthly	1-2 times weekly	3-6 times weekly	Daily	Unknown
1. In a commercial casino							
2. In a charity gaming club							
3. In a bingo hall							
4. At the race track							
5. At an off-track betting location							
6. On the internet							
7. On the television							
8. On the telephone							
9. Lottery kiosk/outlet							
10. In family/friends setting							
11. In a social club							
12. In a restaurant/bar							
13. In a school setting							
14. In a work setting							
15. In a seniors centre/home							
16. In a custody/correctional facility							
17. Somewhere else in the community							

6. (b) Please indicate the top three locations for gambling, using the numbers in 6 (a).
   Major _____ 1st other _____ 2nd other _____

7. Thinking about the times you gambled in the past 12 months, what percent were:
   (a) In Ontario _____% (b) In another province _____% (c) Outside of Canada _____%